Louisiana State Board of Medical Examiners

Physical Address: 630 Camp Street, New Orleans, LA 70130
Mailing Address: P.O. Box 30250, New Orleans, LA 70190-0250
Phone: (504) 568-6820, Fax: (504) 599-0503

ACUPUNCTURIST / ASSISTANT QUALIFICATIONS / INSTRUCTIONS

(Rev. 022405)

QUALIFICATIONS FOR CERTIFICATION

ACUPUNCTURIST

To be eligible for certification as an acupuncturist, an applicant shall:

1. Be a physician possessing a current, unrestricted license to practice medicine in the State of Louisiana duly issued by the board;
2. Be of good moral character; and
3. Have successfully completed not less than six months of training in traditional Chinese acupuncture in a school or clinic approved by the board; or
4. Completed three hundred credit hours of continuing medical education in acupuncture designated as category one continuing medical education hours by the American Medical Association.

The burden of satisfying the board as to the qualifications and eligibility of the applicant for certification shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by, and to the satisfaction of, the board.

Checklist:

- Certificate of completion of six months training in traditional Chinese Acupuncture.
- 1 recent photograph.

NOTE: All documents required to be submitted to the board must be the original thereof. All documentation submitted in a language other than English shall be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of perjury. See discussion, “Translations” herein.

ACUPUNCTURIST ASSISTANT

A. To be eligible for certification as an acupuncturist's assistant, an applicant:
   1. shall be at least 21 years of age;
   2. shall be of good moral character;
   3. shall have successfully completed a four-year course of instruction in a high school or its equivalent;
   4. shall be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service of the United States under and pursuant to the Immigration and Nationality Act and the commissioner's regulations;
   5. shall have:
      a. successfully completed not less than 36 months of training in traditional Chinese acupuncture in a school or clinic approved by the board; or
      b. successfully passed the certification examination given by the National Certification Commission for Acupuncture and Oriental Medicine
      c. have been formally appointed or employed to perform acupuncture exclusively for research purposes by and at:
         - an accredited licensed hospital located in the state of Louisiana; or
         - an accredited school or college of medicine located in the state of Louisiana.

B. To be eligible for approval under this chapter, a proposed supervising physician shall, as of the date of the application:
   1. possess a current, unrestricted license to practice medicine in the state of Louisiana; and
   2. have been in the active practice of medicine for at least five years following the completion of postgraduate residency training, if any.

C. The burden of satisfying the board as to the qualifications and eligibility of the applicant and proposed supervising physician for certification and approval shall be upon the applicant and proposed supervising physician, who shall demonstrate and evidence such qualifications in the manner prescribed by, and to the satisfaction of, the Board.

Checklist

- Original or certified copy of high school diploma.
- Certificate of completion of 36 months instruction in traditional Chinese acupuncture.
- 1 recent photograph.
- Criminal Background Check Materials
- a detailed description of the proposed supervising physician's professional background and specialty, if any; the nature and scope of his medical practice; the geographic and demographic characteristics of his medical practice; the address or location of the office where the applicant is to be employed.
- a description of the proposed supervising physician's knowledge of and prior training or experience, if any, in traditional Chinese acupuncture.
- a description of the specific activities to be performed by the applicant, the way in which the applicant will be utilized as an acupuncturist's assistant, and the methods to be used by the proposed supervising physician to insure responsible direction and control of the activities of the applicant as an acupuncturist's assistant.
- See discussion of birth certificates and passports herein.
- Criminal Background Check Materials.

GENERAL INFORMATION

The state of Louisiana does criminal background checks as part of the application process through the state -Louisiana Department of Public Safety and Corrections-DOC and Federal Bureau of Investigations-FBI. Materials for this purpose can be obtained by writing to:

LSBME-Attn: CB
P O Box 30250
New Orleans, LA 70190-0250

Or by e-mail at lsbmemat@lsbme.louisiana.gov

Applicants with criminal history may expect delays in the application process.

Notarized Birth Certificate

The applicant must submit a notarized birth certificate or an original passport (expired passports are acceptable). The notarized birth certificate becomes a permanent part of the applicant's file and is not returned. If the applicant submits a passport, the applicant must include a written explanation of the reason the birth certificate is not available.

Valid Visa

Applicants who are not native-born citizens of the United States must show proof of legal entry into the United States to work and reside by presenting either:

- An original certificate of Naturalization
- Certified birth certificate establishing birth to U.S. citizens traveling abroad
- Valid Visa issued by the department of Immigration and Naturalization (INS). (Acceptable visas – J-1, H-1B, Immigrant)

Personal Appearance

A personal appearance with a member of the Louisiana State Board of Medical Examiners (the "Board") or its designee is required of each applicant. Personal appearances are by appointments only and can only be scheduled after receipt of ALL application materials. At the time of the personal appearance, you must present the ORIGINAL of the following documents (copies should have already been provided). All documents submitted to the board must be the original and must be in English. If the document(s) is not in English, they must be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of the law.

- Diploma from Professional Acupuncture School
- Marriage license and/or court decree of the applicant who applies in a name different from the name on the medical diploma
- High School diploma
- Valid Visa

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FEE SCHEDULE FOR ACUPUNCTURIST/ASSISTANTS

(Rev 050104)

Initial Licensure Fees

Note: If applying for a temporary permit, permanent licensure fee must accompany the temporary permit fee.

Profession		Form Of Payment	**Payable To**	***Amount***	**Send To**	***Total***
ALL APPLICANTS: ***FINGERPRINTS***		Money Order	La. Department of Public Safety and Corrections	$50.00	LSBME	$50.00
For LSBME to return documents to applicant in U.S. by U.S. Certified Mail, Return Receipt Requested.		Check or Money Order	LSBME	$2.55	LSBME	$
For LSBME to return documents to applicant in U.S. by courier.		***SEE INSTRUCTIONS***				----------
Acupuncture / Assistants	Acupuncturist	Check or Money Order		$200.00	LSBME	$
	Acupuncture Assistants	Check or Money Order		$200.00	LSBME	
TOTAL						**$**

*Must Complete Waiver Form

NOTE: The LSBME will notify applicant if insufficient monies are remitted.

Renewal Fees[1]

Discipline	**Scheduled Renewal Fee**
Acupuncturist	$100.00
Acupuncture Assistants	$100.00

[1] Fees are not prorated (i.e. License received mid-year fee payable in full, next annual renewal payable in full)

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MUST BE TYPED *OR* BLOCK PRINTED

ATTACH PHOTO HERE

APPLICATION FOR ACUPUNCTURIST / ASSISTANT

Name: Last		**First**		**Middle**	**Suffix (Sr., Jr.)**	**Suffix (MD/DO)**	
List all names in which you have ever been known:							
Social Security Number			**Driver's License Number & State**				
Address	**Home Address**	**Street & Number**			**City**	**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, number).**		
	Preferred Mailing Address	**Street Number or Post Office Box**			**City**	**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, #, Ext.)**	**Pager Number**	
Identification	**Race**	**Sex**	**Weight**	**Height**	**Eyes**	**Hair**	**Marks**
Birth (must submit ORIGINAL or Certified Copy of birth certificate)	**Place**		**Date**		**Are you a U.S. Citizen?**		
	If not native born citizen of the U.S., give the following information:	**Type of visa:**					
		If Naturalized, give certificate number:					
		INS number:					
		Petition number:					
		Date issued:					
		District court through which issued:					
Marital Status	**Spouses First Name:**	**Last Name (if different from yours)**					
U.S. Active Duty	**Branch**	**Dates Served:** **From:** **To:**			**Discharge**		

Education			Post Graduate Training		
High School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/Year Graduated**		**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**
Professional School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**

Practice History and Non-Professional Activity (Do NOT include Training)
Account for ALL time not specified above, in chronological order, from High School to the present.

From MO/YR	To MO/YR	City	State or Country	Employer or practice setting (Clinic, Hosp., Solo/Group, Etc.)	Specialty or Activity
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				

States in which license/certificate obtained and basis of licensure/certification

Describe previous acupuncturist or acupuncturist's assistant activities in chronological order, indicating nature of such activities, positions held, location and address of such activities, and inclusive dates of such activities.

State the name and address of licensed physicians who supervised your activities as an acupuncturist or acupuncturist's assistant in the activities detailed above.

Have you ever been appointed or employed at a licensed or accredited Louisiana hospital, medical school, or clinic to perform acupuncture for research purposes? _____, if so, state

a. Name and address of such hospital, medical school, or clinic:

b. Inclusive dates of such employment or appointment:

c. Provide a concise statement of the nature and purpose of the research conducted.

d. Attach a copy of the protocol of such research program.

e. State whether or not a report was made of such research and the results thereof: ____. If so, state the title of such report and date thereof:

f. Identify by name, position, and address the person or persons directly responsible for or supervising such research:

g. Attach hereto a notarized certificate from each such person or persons attesting that you were employed or appointed to conduct such research; the nature and purpose of such research; and that such employment or appointment was performed satisfactorily by yourself in accordance with the research protocol.

Employment arrangements:
In the event a certificate to practice as an acupuncturist's assistant is issued by this Board, describe in detail the following:

a. Name, title and professional address of the licensed acupuncturist certified by this Board to practice acupuncture by whom you will be employed.

Name	Title	Professional Address

b. Duties, services, and functions that will be assigned to you by such employer.

c. Address where you will perform such duties, services, and functions.

d. Attach a copy of the employment agreement for such practice.

Attach a check or money order payable to the Louisiana State Board of Medical Examiners in the amount of $200.00 as an application and processing fee. NO FEES ARE REFUNDABLE.

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AFFIDAVIT OF ACUPUNCTURIST ASSISTANT

Parish of _____

State of _____

I hereby certify, under oath, that all statements made in this application are true; that I am the person named in all of the documents attached hereto; that the photograph attached hereto is a true one of myself and it was taken within the last sixty days; and, that I hereby acknowledge and agree that all professional functions performed by myself as an acupuncturist's assistant must be performed within the employment of and under the physical direction, control, and supervision of a physician licensed to practice medicine in the State of Louisiana or an acupuncturist certified by the Louisiana State Board of Medical Examiners to practice acupuncture and that all such duties, services, and functions assigned by such employer must be performed at the place or such employer's practice, unless said duties, services, and functions are performed in the physical presence of such employer.

I further agree, under oath, that any certificate issued to myself as a result of this application is only valid while I am employed by the supervising physician or certified acupuncturist identified in the employment arrangements set forth above; that any change in my employment arrangements specified above will void any certificate issued hereunder and that a new certificate must be obtained by myself in the event I wish to change my employment arrangements.

I further agree, under oath, that any practice of acupuncture by myself outside of the scope of the provisions of the Louisiana Revised Statues 37:1358; or the unauthorized practice of medicine as defined by Louisiana Revised Statues 37:1261 et seq; or the providing of any false information in the application will constitute just cause for revocation by the Louisiana State Board of Medical Examiners of any certificate issued to myself as a result of this application.

Signature _____

Print Name _____

City of _____

State of _____

Subscribed and sworn to before me this _____day

Of _____ YEAR _____

_____
NOTARY PUBLIC

My commission expires_____

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AFFIDAVIT OF SUPERVISING PHYSICIAN FOR AN ACUPUNCTURIST ASSISTANT

Parish of _____

State of _____

BEFORE ME, _____, a Notary Public in and for the Parish of _____, State of Louisiana, came and appeared:

who, after being duly sworn, stated that he will be the supervising physician or supervising certified acupuncturist of _____, who is applying herein for a certificate to practice as an acupuncturist's assistant in the State of Louisiana and that in the event the Louisiana State Board of Medical Examiners issues a certificate to said applicant, that said _____, supervising physician or supervising certified acupuncturist, agrees to employ applicant as an acupuncturist's assistant; agrees to provide direction, control and supervision of all professional activities to be performed by such acupuncturist's assistant in conjunction with said certificate; and shall agree to all duties, services, or functions pertaining to acupuncture as assigned by him to the acupuncturist's assistant.

Signature _____

Print Name _____

Subscribed and sworn to before me this _____day

Of _____ YEAR _____

_____
NOTARY PUBLIC

My commission expires_____

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OATH OR AFFIRMATION

Answer the following questions
(Yes answers must be explained in sworn affidavit *-AFFIDAVIT MUST BE TYPED!*)

		YES	NO
1.	In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2.	In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3.	Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute?		
	b) Federal statute?		
4.	Has your application for examination or license ever been rejected or denied?		
5.	Have you ever failed a licensure/certification examination? If yes, how many times?_____		
6.	Have you ever been denied membership in a state, county, or local professional society?		
7.	Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8.	Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9.	Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10.	Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	**N/A**	**N/A**
11.	Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12.	Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13.	Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14.	Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15.	Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____
Full Name

Subscribed and sworn to before me this _____day

of_____YEAR_____

_____
NOTARY PUBLIC

My commission expires_____

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CERTIFICATE OF PROGRAM CHAIRMAN/HEAD

APPLICANT'S NAME _____

SOCIAL SECURITY NUMBER _____

Section 1: To Applicant—Complete Section 1 before a Notary. Forward this form to Allied Health School.

Recent photograph

Passport quality photograph of Applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

Notary is to affix seal directly on photograph.

Affix Photograph Here
(Follow directions carefully.)

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____Day of _____, 200_____

_____
Notary Public

My commission expires_____

Section 2: To Program Chairman/Head-After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250.
DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree of, or certificate in, _____

Dated _____from this school.

_____ _____
Name of school/program Signature of Medical Dean/Registrar, Allied Program Chairman/Head

_____ _____
Address Title

_____
Date

Affix School Seal Here